

# Queering global health: an urgent call for LGBT+ affirmative practices



Suntosh R Pillay, Joachim M Ntetmen, Juan A Nel



This Viewpoint was submitted in response to the call for papers on the theme “What is wrong with global health?”. We answer the question simply: global health under-represents the experiences of LGBT+ people. Queer contexts are missing from the pages of this journal—a strange exclusion given the journal’s commitment to diversity and inclusion of marginalised voices. Indeed, there is a general neglect within global health scholarship of the intersection between health inequities and LGBT+ populations in low-income and middle-income countries in Africa. This Viewpoint discusses the utility of LGBT-affirmative scholarship developed in South Africa, and its use and application in Nigeria and Cameroon.

## Do queer lives matter?

It is commendable that *The Lancet Global Health* seeks to amplify voices in low-income and middle-income countries (LMICs). However, the meanings of global and of health are not uncomplicated; they are fraught with tension, representing difficult realities of the professional and personal lives of queer people. In line with the global reappropriation of the term queer by LGBT+ activists, we use queer in this Viewpoint as an umbrella term to index the diversity and combinations of sexual orientations, gender identities, and expressions, including but not limited to LGBT+ people. Our use of the term LGBT+ aims to create an inclusive term that acknowledges the diverse spectrum of sexual and gender identities and expressions, such as intersex, asexual, and gender non-conforming people, who are not consistently represented in the traditional LGBT acronym. The call for new contributors to share their expertise and experiences is overdue, given the widespread criminalisation of sexual and gender diversity across the world and the immediate intersection of this criminalisation with inequities in health care.<sup>1-4</sup>

In this spirit, we responded to the invitation to foreground our work done in African LMICs, particularly South Africa, Cameroon, and Nigeria. Our work is rarely acknowledged as global due to socioeconomic power imbalances that predetermine whose work gets published in elite academic journals.<sup>5</sup> Additionally, mental health tends to rank lower in the list of priorities for global health than does physical health. We hope to catalyse debate and help reorient the epistemic focus of global, specifically mental health, knowledge production and dissemination for LGBT+ people.

What is wrong with global health? We have a simple answer: global health under-represents the experiences of queer people. Queer contexts are also missing from the pages of this particular journal, which serves as a powerful mirror for the state of global health more broadly, due to its high impact factor and status as a leading journal in the field. The lack of queer contexts is a strange exclusion when considering global health’s vision of “including the excluded”,<sup>5</sup> and the magnitude of transnational health issues that intersect with LGBT+

populations.<sup>6-8</sup> There is only one brief Correspondence in *The Lancet Global Health* calling for greater intersectoral collaboration and international consensus on LGBT+ health, but it is authored entirely by a UK-affiliated group who use LMICs as an entry point into the discussion.<sup>9</sup> Notwithstanding the Series on transgender health published in the parent journal *The Lancet*,<sup>10</sup> only one empirical article focusing exclusively on LGBT+ people had been published in *The Lancet Global Health* at the time of writing.<sup>11</sup> Men who have sex with men (MSM) are discussed in articles on male circumcision,<sup>12</sup> but these reductive labels of sexual behaviour are rooted in public health language that sit awkwardly with nuanced and diverse self-identifications among LGBT+ communities.<sup>13</sup>

These omissions are glaring given the well-established, disproportionate burden of physical and psychosocial health disparities experienced by LGBT+ people,<sup>14</sup> who have higher rates of both communicable and non-communicable diseases than cisgender, heterosexual people.<sup>15</sup> There are also substantial differences in health outcomes within LGBT+ populations, who are often indiscriminately grouped together in analyses, despite having different experiences.<sup>16</sup>

## Disrupting hetero-cis-normativity

Against this background, we ask a second crucial question: is this journal—and the field of global health—inadvertently, or otherwise, operating from an epistemic position of hetero-cis-normativity?

It seems so. As health-care workers and researchers located across wide-ranging local, national, and international contexts (eg, in public hospitals, universities, non-governmental organisations [NGOs], advocacy initiatives, and policy-making platforms), our collective experiences bear testament to the hetero-cis-normativity of health care. In these health-care contexts, the conceptual binaries of heterosexual and queer, male and female, and masculine and feminine remain rigid.<sup>14,17,18</sup> As described by Melanie Judge, this rigid categorisation is overlaid “with gendered, racialised and classed inequalities, which animate how heterosexuality continues to operate as the privileged, universal and unmarked sexuality, whilst queerness remains minoritised, particularised and othered”.<sup>18</sup> Our

*Lancet Glob Health* 2022;  
10: e574-78

Published Online  
February 14, 2022  
[https://doi.org/10.1016/S2214-109X\(22\)00001-8](https://doi.org/10.1016/S2214-109X(22)00001-8)

King Dinuzulu Hospital Complex, Durban, South Africa (S R Pillay MSocSc); Department of Psychiatry, Nelson R Mandela School of Medicine, University of KwaZulu-Natal, Durban, South Africa (S R Pillay); Alternatives-Cameroon, Douala, Cameroon (J M Ntetman BPsych); Department of Psychology, University of South Africa, Pretoria, South Africa (Prof J A Nel PhD)

Correspondence to:  
Suntosh R Pillay, King Dinuzulu Hospital Complex, Durban 4015, South Africa  
[suntoshpillay@gmail.com](mailto:suntoshpillay@gmail.com)

scholar activism has, therefore, aspired to leverage progressive platforms to actively destabilise these epistemic injustices.<sup>19,20</sup>

In 2013, their position statement on sexual and gender diversity centred the national Psychological Society of South Africa (PsySSA) as an affirmative body that will not tolerate homophobia, biphobia, or transphobia in the profession.<sup>21</sup> An affirmative stance is an ethical practice that includes respectful recognition of diversity among people, and critical, contextual awareness about the struggles and strengths that inform the lived experiences of LGBT+ people. This approach includes condemning so-called conversion therapies that are harmful and scientifically discredited but continue to flourish in both LMICs and high-income countries (HICs).<sup>22</sup> The statement made by the PsySSA evolved into the landmark PsySSA Practice Guidelines for Psychology Professionals Working with Sexually and Gender-Diverse People.<sup>23</sup> These were the first evidence-based, LGBTI+ affirmative health-care guidelines ever endorsed and published by a national body in South Africa, and the first on the African continent more broadly.<sup>23</sup>

Although initially developed for a post-apartheid South African mental health context, the guidelines informed an international policy statement made by the International Psychology Network for Lesbian, Gay, Bisexual, Transgender, and Intersex issues (IPsyNet). By July, 2021, the IPsyNet statement and commitment had received 41 endorsements, and was translated into 13 languages, including the South African languages of Afrikaans and isiZulu.<sup>24</sup> Importantly, the guidelines were co-opted, as interdisciplinary resources for primary health-care interventions, by two other African countries who also participated in the early phases of its development.<sup>20</sup> These position statements and guidelines became more than mere knowledge outputs; they actively destabilised existing orthodoxies in health care and served as key reference points for broader epistemic disruption.

### Colonial continuities of LGBT+ criminalisation

Under ordinary circumstances these achievements might seem unremarkable because LGBT+ affirmative guidelines have been routinely globalised since the American Psychological Association published the first set in 2001. However, in the past 20 years, most core competencies for working with LGBT+ people came from HICs (eg, the USA, Australia, the UK, Ireland, and New Zealand) and were exported to LMICs, fuelling the problematic assumption that Western countries push an LGBT+ agenda. We use the term Western in this context to refer to North America, Europe, and countries connected to a largely secular political system. No African country—except South Africa—has produced its own guidelines. The movement of (South) African queer scholarship as a resource for action in global contexts is, therefore, unusual.

Frameworks developed in Western countries dominate LGBT+ empirical work because of the criminalisation of sexual and gender diversity in African countries. This criminalisation renders global health scholarship for and by African LGBT+ people difficult, and nearly impossible.<sup>19,22</sup> Anti-LGBT+ politics are an enduring artifact of colonial-era laws in Africa, despite an expressed commitment by the African Commission on Human and Peoples' Rights in 2014 to end all such violence.<sup>22</sup> An affirmative agenda is thus intimately linked with efforts to decolonise public health and global health. Our work, therefore, takes place under extraordinary circumstances that cannot be overstated.

Consensual same-sex sexual acts are legal in only 22 of 54 African countries; they are punishable with the death penalty in Mauritania, Nigeria, and Somalia, and punishable with life imprisonment in Sudan, Tanzania, Uganda, and Zambia.<sup>25</sup> Despite the mental health benefits of decriminalising consensual same-sex sexual acts for LGBT+ people, measures to police sexuality are couched as public health concerns. For example, in Kenya, the criminalisation of consensual same-sex sexual acts is framed as an effective method to curb the HIV pandemic.<sup>25</sup> Globally, 69 (35%) of the 193 UN member states criminalise consensual same-sex sexual acts, and only 11 (6%) member states protect the right to sexuality in their national constitution (Bolivia, Cuba, Ecuador, Fiji, Malta, Mexico, Nepal, Portugal, San Marino, South Africa, and Sweden).<sup>25</sup>

WHO remains lacking in conviction in this regard. Their International Classification of Diseases listed transgender issues as mental disorders until 2019.<sup>2</sup> Only in 2013 did WHO produce its first ever report on the health of LGBT+ people, but caved into pressure from African and Middle Eastern countries to remove the report from its Executive Board meeting agenda.<sup>26</sup> Unfortunately, as described by Po-Han Lee, “many governments still regard sexual and gender minorities as ‘irresponsible’ in terms of the global burden of both the HIV epidemic and mental disorders, and such a bias, without reasonable grounds, is one of the greatest impediments that prevents LGBT health from being considered on the global social health agenda”.<sup>26</sup>

Within this vulnerable geopolitical context, the use of progressive, affirmative health-care guidelines is a radical act of resistance against a colonial, archaic, and anti-LGBT+ agenda. We locate our work within these acts of decolonial resistance. We discuss two applications of the guidelines in Cameroon and Nigeria—two countries in which homophobia and transphobia are prevalent, in east and west Africa, respectively.

### Cameroon and Nigeria: precarious possibilities

In 2011 Cameroon included MSM as a key population in its HIV National Strategic Plan, allowing state-endorsed health services to reach this so-called hidden population.<sup>27</sup>

Before 2011, such services were run covertly by community organisations, such as Alternatives-Cameroun. However, a key tension emerged: creating culturally acceptable services in a country where same-sex sexual acts are criminally punished.

Two complementary approaches seemed feasible. The human rights approach—predicated on equality—states that all human beings have a right to health care and that stigmatisation and discrimination against MSM must be stopped.<sup>27</sup> If not stopped, stigmatisation and discrimination would force people to continue hiding from the health system for fear of criminal prosecution. The public health approach—predicated on access—primarily wanted to curb the HIV epidemic in Cameroon. Both approaches advocated for administrative tolerance of politically and socially undesirable groups, who were euphemised as key populations. These approaches included a moratorium on arrests so that MSM could access health care without fear of prosecution.<sup>28</sup> The tensions of administrative tolerance enabled LGBT+ people to inconsistently access health care within a stigmatising system, rather than being excluded completely. Both approaches were a political compromise to catalyse services, but they remained insufficient.

The nature of sexual orientation and gender identity was ignored. LGBT+ people remained a problem to fix, instead of identities to affirm. Discrimination and violence against LGBT+ people continued, as 5873 cases of abuse, including 332 arbitrary arrests, were reported from 2012 to 2020 in Cameroon.<sup>19</sup> There was a clear need to go further and create affirmative services.

Fortunately, Alternatives-Cameroun participated in, and gave critical input to, the drafting of South Africa's guidelines,<sup>23</sup> part of which were subsequently translated into French with plans to translate the remainder. Training was done with 30 personnel at an NGO in Cameroon, where participants selected six of the 12 guidelines as especially valuable to their context. In our experience, the guidelines were useful in a Cameroonian context, not only among health-care workers, but also for police officers, lawyers, and journalists.

Similarly, in Nigeria, because it is against federal law to offer health-care services to LGBT+ people,<sup>25</sup> these services happen in secret, catalysing a “rapid reversal of key public health gains” according to the Academy of Science of South Africa,<sup>22</sup> often without regard for affirmative practice principles. Allies and activists translated the South African guidelines into local Nigerian languages—Hausa, Igbo, and Yoruba—and use them covertly under extraordinarily difficult circumstances. This is an emerging context of application, but debates have also commenced within one of the Nigerian associations for psychologists regarding the urgent need for guidelines, similar to those of South Africa, on high-quality, LGBT+ focused, mental-health services.

These two brief examples provide a snapshot into how progressive scholarship can disrupt the status quo

through practical interventions that transform global health problems into locally tailored solutions. This approach begins to narrow the gap in exclusionary practices by disrupting epistemic privileging of hetero-cis-normative health care and its colonial continuities in African contexts.

### Can we queer global health?

We have argued, in part, that global health underrepresents the experiences of LGBT+ people and that hetero-cis-normativity is a dangerous political and social determinant of health. The Cameroonian and Nigerian stories are instructive. The agility of a science-based, affirmative framework for LGBT+ health care renders it especially valuable for (covert) task-shifting interventions that can be adopted by a diverse range of personnel, even those outside the formal health-care system. South Africa's affirmative guidelines, although initially conceptualised as profession-specific and country-specific, became a transnational, interdisciplinary, and alternative framework to compensate for an absence of protective laws for LGBT+ people in varied oppressive contexts.

#### Panel: Summary of LGBT+ affirmative practice points for global health

The Psychological Society of South Africa provides a framework to move research and applied practices towards a shared vision of global affirmative health care.<sup>21,23</sup> Recognising the harm that has been done to LGBT+ individuals and groups by historical and contemporary prejudices, and by discrimination against sexual and gender diversity, global health programmes must urgently affirm:

- 1 Non-discrimination and respect for human rights
- 2 Individual self-determination
- 3 Gender fluidity and biological diversity
- 4 An awareness of hetero-cis-normative social contexts
- 5 Critical intersectionality
- 6 Counteraction of stigma and violence
- 7 Recognition of multiple developmental pathways from infancy to older age
- 8 Non-conforming family structures and relationships
- 9 The necessity of an affirmative stance across all professional activities, including research, teaching, policy development, and health care
- 10 Global best practices in (transgender) health care
- 11 Disclosing and rectifying personal, institutional, or cultural biases
- 12 Continued professional development to regularly update knowledge

Each of these practice points must be adapted for local contexts, provided they trouble rigid conceptual boundaries between male and female, masculine and feminine, and heterosexual and queer.

An affirmative philosophy to health care is a counterweight to punitive practices. The Yogyakarta Principles on the application of international human rights law in relation to sexual orientation and gender identity call for competently trained health-care providers.<sup>29</sup> Health-care facilities around the world must strive to be the safe spaces that LGBT+ people desperately need.<sup>7</sup> This endeavour will accord with the third goal of the UN 2030 Agenda for Sustainable Development, which is to ensure healthy lives and promote wellbeing for all at all ages.<sup>24</sup> Indeed, as explained by Pachankis and Bränström, “the surest route to improving the wellbeing of sexual minorities worldwide is through reducing structural forms of inequality”.<sup>7</sup> Global affirmative health can transcend local, national, and political boundaries to give voice to these goals (panel).

We end with a hopeful question: can we queer global health? Yes, we can! We draw on South African scholar activists Zethu Matebeni and Jabu Pereira: to queer is understood to be “an inquiry into the present, ... a critical space that pushes the boundaries of what is embraced as normative [to] speak back to hegemony [and challenge] various norms on gender, sexuality, existence and ... being”.<sup>30</sup>

To queer global health, we must rebel towards global justice. Boundaries must be bravely transgressed as processes of “queer disturbance”.<sup>18</sup> This process requires more content and empirical research related to queer communities, but also a substantive epistemic turn towards “the transformative potential of queerness” for critical theorising in global health.<sup>18</sup> A queer turn must centre on the lived experiences of individuals and communities, decolonial qualitative inquiry, creative and participatory methods such as Photovoice, and queer research from, for, and with LMICs. An unapologetically critical field that embraces scholar activism will no longer lead us to question what is wrong with global health—as this journal prompted us to do—but might invite us to celebrate what is right. To do so, global health must refrain from being a culture bearer of hetero-cis-normativity (panel). This need is pressing and requires an urgent call to action. Are we up for the challenge?

#### Contributors

SRP conceptualised the Viewpoint and wrote the original draft. JMN and JAN reviewed and edited the Viewpoint. All authors conducted literature searches.

#### Declaration of interests

The work reported on in this Viewpoint was funded by the Arcus Foundation. SRP and JAN are both council members of the Psychological Society of South Africa (PsySSA) and JMN is Program Director at Alternatives-Cameroun. Both PsySSA and Alternatives-Cameroun are non-profit organisations. We declare no other competing interests.

#### References

- 1 Ayhan CHB, Bilgin H, Uluman OT, Sukut O, Yilmaz S, Buzlu S. A systematic review of the discrimination against sexual and gender minority in health care settings. *Int J Health Serv* 2020; **50**: 44–61.

- 2 Luvuno ZP, Mchunu G, Ncama B, Ngidi H, Mashamba-Thompson T. Evidence of interventions for improving healthcare access for lesbian, gay, bisexual and transgender people in South Africa: a scoping review. *Afr J Prim Health Care Fam Med* 2019; **11**: e1–10.
- 3 Muller A, Hughes TL. Making the invisible visible: a systematic review of sexual minority women’s health in Southern Africa. *BMC Public Health* 2016; **16**: 1–8.
- 4 Scheim A, Kacholia V, Logie C, Chakrapani V, Ranade K, Gupta S. Health of transgender men in low-income and middle-income countries: a scoping review. *BMJ Glob Health* 2020; **5**: 1–13.
- 5 Sharma D. A call for reforms in global health publications. *Lancet Glob Health* 2021; **9**: e901–02.
- 6 Koch JM, McLachlan C, Victor CJ, Westcott J, Yager C. The cost of being transgender: where socio-economic status, global health care systems, and gender identity intersect. *Psychol Sex* 2020; **11**: 103–19.
- 7 Pachankis JE, Bränström R. How many sexual minorities are hidden? Projecting the size of the global closet with implications for policy and public health. *PLoS One* 2019; **14**: 1–12.
- 8 Poteat T, Stahlman S. Global health/LGBTQ health. In: Stall R, Dodge B, Bauermeister JA, Poteat T, Beyrer C, eds. *LGBTQ health research: theory, methods, practice*. Baltimore, MD: Johns Hopkins University Press, 2020: 37–48.
- 9 Scherdel L, Martin A, Deivanayagam A, Adams E, Shanahan T. The search for international consensus on LGBT health. *Lancet Glob Health* 2014; **2**: e321.
- 10 Winter S, Settle E, Wylie K, et al. Synergies in health and human rights: a call to action to improve transgender health. *Lancet* 2016; **388**: 318–21.
- 11 Kaplan RL, Veerina A, El Khoury C. Visibility, transphobia, and resilience: addressing transgender women’s health in Lebanon. *Lancet Glob Health* 2019; **7**: 5.
- 12 Yuan T, Fitzpatrick T, Ko NY, et al. Circumcision to prevent HIV and other sexually transmitted infections in men who have sex with men: a systematic review and meta-analysis of global data. *Lancet Glob Health* 2019; **7**: e436–47.
- 13 Young RM, Meyer IH. The trouble with “MSM” and “WSW”: erasure of the sexual-minority person in public health discourse. *Am J Public Health* 2005; **95**: 1144–49.
- 14 Zeeman L, Sherriff N, Browne K, et al. A review of lesbian, gay, bisexual, trans and intersex (LGBTI) health and healthcare inequalities. *Eur J Public Health* 2019; **29**: 974–80.
- 15 Mongelli F, Perrone D, Balducci J, et al. Minority stress and mental health among LGBT populations: an update on the evidence. *Minerva Psichiatr* 2019; **60**: 27–50.
- 16 Pratt-Chapman ML, Alpert AB, Castillo DA. Health outcomes of sexual and gender minorities after cancer: a systematic review. *Syst Rev* 2021; **10**: 1–30.
- 17 Heise L, Greene ME, Opper N, et al. Gender inequality and restrictive gender norms: framing the challenges to health. *Lancet* 2019; **393**: 2440–54.
- 18 Judge M. Queer at 25: a critical perspective on queerness, politics and futures. *J Asian Afr Stud* 2021; **56**: 120–34.
- 19 Humanity First Cameroon, Alternatives-Cameroun. Un silence complice: rapport annuel 2019: des violences et violation des droits sur la base de l’orientation sexuelle, l’identité de genre et l’expression des caractéristiques sexuelles. 2019. <https://76crimesfr.files.wordpress.com/2020/05/rapport-annuel-2019-de-violation-des-droits-des-msg-au-cameroun.pdf> (accessed Sept 20, 2021).
- 20 Pillay SR, Nel JA, McLachlan C, Victor CJ. Queering the history of South African psychology: from apartheid to LGBTI+ affirmative practices. *Am Psychol* 2019; **74**: 954–66.
- 21 Victor CJ, Nel JA, Lynch I, Mbatha K. The Psychological Society of South Africa sexual and gender diversity position statement: contributing towards a just society. *South African J Psychol* 2014; **44**: 292–302.
- 22 Academy of Science of South Africa (ASSAF). Diversity in human sexuality: implications for policy in Africa. 2015. <https://www.assaf.org.za/files/8-June-Diversity-in-human-sexuality1.pdf> (accessed Sept 20, 2021).
- 23 McLachlan C, Nel JA, Pillay SR, Victor CJ. The Psychological Society of South Africa’s guidelines for psychology professionals working with sexually and gender-diverse people: towards inclusive and affirmative practice. *South African J Psychol* 2019; **49**: 314–24.

- 24 Koch JM, Chiao H, Nel JA. Preparing future generations: critical considerations and best practices in training psychologists about the human rights of sexually and gender-diverse people and communities. In: Rubin NS, Flores R, eds. *Cambridge handbook of psychology and human rights*. Cambridge: Cambridge University press, 2021: 520–34.
- 25 Mendos LR, Botha K, Lelis RC, Peña EL, Svalev I, Daron T. State-sponsored homophobia 2020: global legislation update. 2020. <https://ilga.org/state-sponsored-homophobia-report-2020-global-legislation-overview> (accessed Sept 20, 2021).
- 26 Lee PH. The demagogies of 'lack': the WHO's ambivalence to the right to health of LGBT people. *Glob Health Gov* 2018; **XII**: 17–21.
- 27 National AIDS Control Committee, Central Technical Group. Plan strategique national de lutte contre le VIH le Sida et les IST 2011–2015. Yaoundé; 2010. <http://www.ilo.org/dyn/natlex/docs/ELECTRONIC/99129/118193/F-746502152/CMR-99129.pdf> (accessed Sept 1, 2021).
- 28 Human Rights Watch. Guilty by association: human rights violations in the enforcement of Cameroon's anti-homosexuality law. 2013. <https://www.hrw.org/report/2013/03/21/guilty-association/human-rights-violations-enforcement-camerouns-anti> (accessed Sept 1, 2021).
- 29 International Commission of Jurists. The Yogyakarta Principles plus 10. 2017 <https://yogyakartaprinciples.org/principles-en/yp10/> (accessed Sept 1, 2021).
- 30 Matebeni Z, ed. *Reclaiming Afrikan: queer perspectives on sexual and gender identities*. Cape Town: Modjaji Books, 2014.

Copyright © 2022 The Author(s). Published by Elsevier Ltd. This is an Open Access article under the CC BY 4.0 license.